Document:	Document #:	Issue Date:	Revision #:	Revision Date:
Benefit Action Form	BEN-BA-001	12/16/2009	001	12/16/2009

Fermilab EMPLOYEE GROUP BENEFIT ACTION FORM

ID: **LAST NAME:** **FIRST NAME:** **M.I.:**

ADDRESS: **CITY:** **STATE:** **ZIPCODE:**

DATE OF BIRTH: **SOCIAL SECURITY NUMBER:** **HOME PHONE NUMBER:**

Select One: ☐ New Employee ☐ Rehire ☐ Reinstatement ☐ COBRA ☐ Other

Select One: ☐ Full-Time ☐ Part-Time

Reason for Change: ☐ Beneficiary ☐ Add Dependent ☐ Delete Dependent ☐ Address ☐ Marriage ☐ Adoption

☐ Marital Status_____ ☐ Other_____

Office Use Only:

☐ Long-Term Disability Insurance **Effective Date:** **Time Reporting:** ☐ Exempt (Monthly)

☐ Sick Leave, Vacation, Floating Holiday ☐ Non-Exempt (Weekly)

MEDICAL COVERAGE SELECT ONE:

- ☐ CERN (Medical and Dental)
- ☐ CIGNA Open Access Plus [FACT]
- ☐ CIGNA Network POS [FACT] - 100IL053
- ☐ HMO Illinois [0000]
- ☐ BLUE Advantage HMO [0000]
- ☐ WAIVE COVERAGE*

LEVEL OF COVERAGE:

- ☐ Employee Only
- ☐ Family

Effective Date (Office Use Only):

* I waive coverage because I and/or my dependents have medical coverage under another plan for which I am required to provide proof. I understand by waiving coverage that I can subsequently enroll only during the annual enrollment period or when I qualify under special enrollment requirements under the Health Insurance Portability and Accountability Act of 1996.

Initial Enrollment: List below yourself and all eligible dependent(s) you are enrolling in your plan. Adding Dependent(s) to Coverage: List below only the new dependent(s) you are adding to your plan.
Dropping Dependent(s) From Coverage: List below only the dependent(s) you are dropping from your coverage and write "cancel" next to their name(s).

Name: Last / First / M.I.	Social Security Number (If Available)	Sex	Date of Birth	Blue Advantage, HMO IL, & Cigna POS Primary Care MD Name	Blue Advantage, HMO IL, (3 digit medical group#) or Cigna POS MD#
Self:					
Spouse:					
Dependent 1:					
Dependent 2:					
Dependent 3:					

DENTAL COVERAGE SELECT ONE:

- ☐ CERN (included with medical)
- ☐ CIGNA Dental PPO [FACT]
- ☐ CIGNA Dental Health (HMO) [FACT]
- ☐ WAIVE COVERAGE*

LEVEL OF COVERAGE:

- ☐ Employee Only
- ☐ Family

Effective Date (Office Use Only):

* If you waive dental coverage for yourself or your dependents (including your spouse), you can only subsequently enroll at the next annual enrollment or when you qualify under special enrollment requirements under the Health Insurance Portability and Accountability Act of 1996.

Initial Enrollment: List below yourself and all eligible dependent(s) you are enrolling in your plan. Adding Dependent(s) to Coverage: List below only the new dependent(s) you are adding to your plan.
Dropping Dependent(s) From Coverage: List below only the dependent(s) you are dropping from your coverage and write "cancel" next to their name(s).

Name: Last / First / M.I.	Social Security Number (If Available)	Sex	Date of Birth	CIGNA Dental Health (HMO) Enter 6 Digit Dental Office#
Self:				
Spouse:				
Dependent 1:				
Dependent 2:				
Dependent 3:				

Last Name: _____ First Name: _____

CIGNA LIFE INSURANCE OPTIONS:

EMPLOYEE COVERAGE:

- ☐ BASIC (No Charge) - 1x Salary [BASIC]
- ☐ SUPPLEMENTAL I - 2x Salary [SUPLF1]
- ☐ SUPPLEMENTAL II - 3x Salary [SUPLF2]
- ☐ SUPPLEMENTAL III* - 4x Salary [SUPLF3] EOI ☐ Yes ☐ No
- ☐ SUPPLEMENTAL IV* - 5x Salary [SUPLF4] EOI ☐ Yes ☐ No

DEPENDENT COVERAGE:

- ☐ OPTION A** (Spouse $5,000/Child(ren) $2,000) [DEP-A]
- ☐ OPTION B** (Spouse $10,000/Child(ren) $4,000) [DEP-B]

Effective Date (Office Use Only):

* Medical Evidence of Insurability required, contact Benefits Office for insurance application.
** Option A and Option B requires Supplemental enrollment (see Summary of Plan Benefits).

LIFE INSURANCE BENEFICIARY:

PRIMARY BENEFICIARY	Address (if different from yours)	Relationship	Sex	Date of Birth	% or Flat Amount
SECONDARY BENEFICIARY	**Address (if different from yours)**	**Relationship**	**Sex**	**Date of Birth**	**% or Flat Amount**

The above beneficiaries apply to the employee's coverage. The employee is the beneficiary of the dependent coverage. Unless otherwise provided, where two or more beneficiaries are named, the proceeds shall be paid in equal shares to the named beneficiaries, if surviving the insured, or to the survivor or survivors. If no beneficiary survives, payment shall be made in accordance with the terms of the policy. This designation revokes any and all previous designations. The right to further change the beneficiary is reserved to the insured.

FLEXIBLE SPENDING ACCOUNT ENROLLMENT FORM:

I hereby authorize Fermilab to reduce my earnings for the current plan year for deposit into my Health and/or Dependent Care Reimbursement Account and to make this money available to me for the reimbursement of eligible out-of-pocket health expenses. **I UNDERSTAND THAT I WILL FORFEIT ANY UNUSED BALANCE IN MY ACCOUNT AT THE END OF THE PLAN YEAR FILING PERIOD. I ALSO UNDERSTAND THAT I CANNOT CHANGE MY PLAN PARTICIPATION UNLESS I HAVE A CHANGE IN FAMILY STATUS, AS DEFINED BY INTERNAL REVENUE CODE SECTION 125.**

Health Care Annual Contribution Amount $_____(Maximum Contribution is $5,000)

Dependent Care Annual Contribution Amount $_____(Maximum Contribution is $5,000)

Note: Salary reduction elections must be made in whole dollar amounts. These elections will be divided by the number of pay periods in the current plan year and be credited to your Account (s) on a monthly basis. Your salary reduction is made on a pre-tax basis in accordance with the IRS Section 125 guidelines.

Office Use Only.

Health Care: Goal Amount $_____ Effective: _____

Dependent Care: Goal Amount $_____ Effective: _____

EMPLOYEE NOTIFICATION:

Single employees are eligible to select only one health plan. Married employees are eligible to select only one health plan for themselves and their dependents. (If both husband and wife are employees of the URA/Fermilab, they cannot be covered under more than one health plan. Each can be in a separate plan, but each cannot be covered under two plans. Their eligible children are covered as dependents of only one parent.)

EMPLOYEE AUTHORIZATION AND CERTIFICATION:

I authorize Fermilab to deduct from my paycheck the appropriate contributions, if any, to the employee benefit plans that I have elected. Contributions for medical and dental coverage will be done on a before tax basis unless the employee signs a waiver form. I hereby certify that the information I have provided on this form is true and correct to the best of my knowledge.

EMPLOYEE SIGNATURE **DATE** **BENEFITS OFFICE** **DATE**